GENERAL INFORMATION

Today's Date:_____

Your Full Name:_____ Age: Date of Birth:_____

Address:_____ City State Zip_____

Name of person completing this form:_____

Which X&Y Chromosome Variation (i.e. XXY, XYY, XXYY, XXX) do you have?_____

You were diagnosed: ☐Prenatally ☐before age 5 ☐age 5-11 ☐age 12-18 ☐after age 18

When did you learn your diagnosis? _____ Who told you?_____

Approx. weight ?_____ Approx. Height?_____

CURRENT FAMILY SITUATION

Mother's Name:_____ Age: Education:_____

Relationship to you : ☐Natural Parent ☐Step-Parent ☐Adoptive Parent ☐Foster Parent

Address:_____ City State Zip_____

Home Phone:_____ Cell Phone: Work Phone:_____

Email Address:_____ Is email a reliable way to contact her? ☐Yes ☐No

Father's Name:_____ Age: Education:_____

Relationship to you : ☐Natural Parent ☐Step-Parent ☐Adoptive Parent ☐Foster Parent

Address:_____ City State Zip_____

Home Phone:_____ Cell Phone: Work Phone:_____

Email Address:_____ Is email a reliable way to contact him? ☐Yes ☐No

With which parent(s) do you the live? ☐Both ☐Mother ☐Father ☐Neither ☐Other

If Parents are separated or divorced, what year did this happen?_____

Do any other adults live in your home? ☐Yes ☐No If yes, Name, Age, Relationship:_____

Doctor's Name_____ Phone

Address:_____ City State Zip_____

IN THE SPACE BELOW, PLEASE DISCUSS YOUR PRIMARY CONCERNS AND/OR WHAT YOU PRIMARILY WISH TO TALK ABOUT DURING YOUR APPOINTMENT(S) IN OUR CLINIC:

BIRTH INFORMATION

Birth weight?_____Type of Delivery? ☐Vaginal ☐Cesarean ☐Twins

Describe any complications during delivery or in the hospital if known:_____

_____

_____

PREGNANCY INFORMATION

Mother's age during this pregnancy?_____ Father's age during this pregnancy?_____

Did your mother have any medical problems during or immediately before/after the pregnancy? (Vaginal infections, Urinary Tract Infections, Flus/Sore Throats, Seizures, High Blood Pressure, Diabetes, Premature labor, Anemia, Vaginal bleeding, Toxemia, Injuries, Emotional Problems?)

_____

_____

_____

_____

BEHAVIORAL/PSYCHOLOGICAL INFORMATION

Do you currently have, or had in the past, any of the following behaviors on a regular basis.(Check all that apply)

- ☐ Temper tantrums/Oppositional behavior
- ☐ Impulsive
- ☐ Hyperactive
- ☐ Short attention span/distractible
- ☐ Repetitive Behaviors
- ☐ Perseveration (conversation fixed on specific idea/topics)
- ☐ Aggressive/destructive behaviors
- ☐ Hand flapping
- ☐ Rocking/spinning
- ☐ Nailbiting
- ☐ Picks/scratches body
- ☐ Poor coordination
- ☐ Bed wetting/soiling
- ☐ Daydreaming
- ☐ Poor eye contact
- ☐ Isolated/withdrawn
- ☐ Overly dependent/immature
- ☐ Low self-esteem
- ☐ Shyness
- ☐ Excessive worries/fears
- ☐ Doesn't like to be touched
- ☐ Bothered by things touching him (tags on his clothing, collars, belts, jewelry etc.)
- ☐ Motor tics
- ☐ Verbal tics
- ☐ Resistance to change in routine
- ☐ Cries often
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Reclusive/isolated behavior
- ☐ Moodiness/irritability
- ☐ Hallucinations (visual or auditory)
- ☐ Suicidal thoughts
- ☐ Sleep problems/Nightmares
- ☐ Masturbates excessively
- ☐ Self injurious (head bangs, bites/hits self)
- ☐ Obscene speech or unfiltered speech
- ☐ Fire setting
- ☐ Stealing/Lying
- ☐ Running away
- ☐ School refusal/truancy

Social behavior

Do you make good eye contact?	☐Yes	☐No
Do you have friends?	☐Yes	☐No
Do you have a fear of public places/crowds?	☐Yes	☐No
Do you have poor social skills?	☐Yes	☐No
Do you have frequent conflicts with peers?	☐Yes	☐No
Are you mean to others/bullying?	☐Yes	☐No
Are you a victim of bullying?	☐Yes	☐No
Have you behavior resulted in problems at school?	☐Yes	☐No
Have you had any problems with the law?	☐Yes	☐No
Do you smoke, use alcohol, illegal drugs?	☐Yes	☐No

PREVIOUS PSYCHOLOGICAL & DEVELOPMENTAL EVALUATIONS

Have you been previously evaluated for developmental, behavioral, emotional, or learning problems? ☐Yes ☐No

Who performed the previous treatments/evaluations/diagnostic tests? What were the results?
Please include provider name, date performed and results

☐Developmental Pediatrician _____
☐Neurologist _____
☐Psychologist _____
☐Psychiatrist _____
☐Speech-Language Therapist _____
☐Occupational Therapist _____
☐Physical Therapist _____
☐Mental Health Therapist/Counselor _____
☐Other _____

Have you been previously been diagnosed with? (Please check all that apply)

- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Autism, Asperger's Syndrome, or Pervasive Developmental Disorder (PDD)
- ☐ Learning disability
- ☐ Reading disability
- ☐ Speech delay
- ☐ Mental retardation
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Sensory Integration Disorder
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Other behavorial, psychologic, or psychiatric disorder?

Have you ever been hospitalized for psychiatric reasons? ☐No ☐Yes If yes, please explain (when, how long, where, did it help):

_____
_____
_____
_____
_____
_____
_____
_____

EDUCATIONAL HISTORY

Did you attend:

☐Elementary/Middle school?	If yes, until what age?	☐Private	☐Public	Completed Grade Level
☐High school?	If yes, until what age?	☐Private	☐Public	Completed Grade Level
☐College?	If yes, until what age?	☐Private	☐Public	Completed Grade Level

Have you ever repeated a grade? ☐Yes. What grade?_____ ☐No

School Assessments and Intervention
Did you have special education testing in school?

- ☐ Psychological/Cognitive Date:_____
- ☐ Academic Date:_____
- ☐ Speech/Language Date:_____
- ☐ Other Date:_____

Did you have an IEP? ☐Yes, when?_____ ☐No

Special Education Classes/Services: Please check all that apply (Specifiy what grade/frequency/duration)

☐Special Education

☐Learning Disability

☐Speech/Language Therapy

☐Occupation/Physical therapy

☐Behaviorally/emotionally handicapped

☐Other health impaired

☐Other

Please list all other agencies and intervention services (e.g. speech therapy, OT, PT) involved with your care and education (e.g. Regional Center, Healthy Start, Protective Services, Early Intervention, etc.)

MEDICAL PROBLEMS/EVALUATIONS

Do you have other medical problems? Please check all that apply and explain, please include problems which have been treated in the past

☐ Ears? (Hearing problems, ear infections, etc.)

☐ Eyes? (Visual problems, strabismus, etc.)

☐ Dental? (Cavities, late tooth eruption, etc.)

☐ Neurologic Problems? (Seizures, tremors, brain malformations, abnormal muscle tone, etc.)

☐ Headaches? (Migraines, etc.)

☐ Lung problems? (Asthma, lung disease, breathing problems)

☐ Cardiovascular/Heart problems? (heart defects, murmurs, irregular rhythm, valve problem, circulation)

☐ High or low blood pressure?

☐ Stomach/Intestinal/Esophageal problems? (reflux/heartburn, ulcers, constipation, abdominal pain)

☐ Liver problems?

☐ Genitalia/Urologic Problems? (undescended/small testicles, problems with urination, hernia, infections)

☐ Abnormal Pubertal development? (early, delayed or abnormal puberty, gynecomastia/breast enlargement

☐ Thyroid problems?

☐ Diabetes?

☐ Orthopedic/Rheumatologic problems (Malformation of limbs/hands/feet, joint problems/pain, flat feet, etc.)

☐ Back problems? (scoliosis, kyphosis, other back abnormalities)

☐ Skin or Hair problems? (rashes, skin ulcers/sores, birthmarks, etc)

☐ Allergies? (food, environmental, medications)

☐ Blood problems (anemia, abnormal white blood cells, abnormal platelets)

☐ Frequent Infections? (skin, respiratory, urinary infections)

Have you had any of the following diagnostic tests? (dates and results, if known)

☐EEG (brain wave test)

☐MRI

☐CT Scan

☐Blood Test (other than routine blood count)

☐Chromosomal/DNA testing

☐Vision Test

☐Other (specify)

Which other types of medical specialists have seen and evaluated/treated you?

Have you ever been hospitalized? ☐Yes ☐No

Have you ever had surgery? ☐Yes ☐No

If hospitalized and/or surgery, when and why?

Please list all current medications and supplements:

Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?
Medication name:	Dose	How Often?

FAMILY MEDICAL HISTORY

Mother: Health, learning, mental health problems? ☐Yes ☐No If yes, please describe:

Medications she is currently taking?

Number of Brothers: Number of sisters: Numbers of Nieces/Nephews:

Father: Health, learning, mental health problems? ☐Yes ☐No If yes, please describe:

Medications he is currently taking?

Number of Brothers: Number of sisters: Numbers of Nieces/Nephews:

Are there any medical illnesses in other family members? (Please specify who)

☐Birth defect	☐Diabetes	☐Mental Retardation
☐Speech/Language delay	☐High Blood Pressure	☐Learning Disability
☐Chromosomal disorder/genetic syndrome	☐Seizures	☐Depression
☐Autism/PDD	☐Kidney Disease	☐Anxiety Problems
☐Alcohol/Drug Abuse	☐Cancer	☐ADD/ADHD

☐Other: (Please describe)

Finding out about Sex Chromosome Aneuploidy

Today's date: _____

Your birth date: _____

Your current age: _____

Which type of SCA Do you have? (47,XXY; 47,XXX; 47,XYY, etc): _____

1. At what age did someone first express concern (development, behavior, physical appearance) to your physician?

_____

2. Who first became concerned or suspected a diagnosis of SCA (parents, teachers, physicians, spouse)?

_____

3. What was the first concerning sign or symptom (development, behavior, physical)?

_____

_____

_____

4. If the concerning symptom was developmental delay, at what age did the professional confirm you had delays?

_____

a. When did you first receive early intervention therapies?

_____

5. How many times did you visit any doctor or health care professional about concerns before chromosomal testing was ordered for you?

_____

6. Who first recommended a chromosome test (parents, teachers, friend, endocrinologist)?

_____

7. At what age was a chromosome test ordered? _____

8. At what age did you receive the SCA diagnosis? _____

9. Who made the diagnosis? (geneticist, endocrinologist, developmental pediatrician) _____

X&Y CHROMOSOME VARIATION MEDICATION PROFILE – PART ONE - CURRENT MEDICATIONS

PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING BELOW.

#1) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____Which doctor started this medication?_____
Has the medication dosage been changed since the medication was started? ☐Yes ☐No
If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same
☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

_____

Does this medication have any side effects in you? ☐Yes ☐No
If yes, please explain.

#2) Medication Name_____
Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____Which doctor started this medication?_____
Has the medication dosage been changed since the medication was started? ☐Yes ☐No
If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same
☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

_____

Does this medication have any side effects in you? ☐Yes ☐No
If yes, please explain.

#3) Medication Name _____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____Which doctor started this medication?_____
Has the medication dosage been changed since the medication was started? ☐Yes ☐No
If yes, how has it changed? Why was it changed?

_____

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

_____

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same
☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

_____

Does this medication have any side effects in you? ☐Yes ☐No
If yes, please explain.

#4) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

Does this medication have any side effects in you? ☐Yes ☐No

If yes, please explain.

#5) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____

Has the medication dosage been changed since the medication was started? ☐Yes ☐No

If yes, how has it changed? Why was it changed?

Why was the medication started? Which symptom(s) or problem(s) is the medication intended to treat?

Has the medication helped these symptoms?

☐ Yes – the symptoms are significantly improved ☐ No – the symptoms are the same

☐ Yes – the symptoms are slightly improved ☐ No – the symptoms are worse than before starting the medication

Please explain your answer above:

Does this medication have any side effects in you? ☐Yes ☐No

If yes, please explain.

X&Y CHROMOSOME VARIATION MEDICATION PROFILE – PART TWO - PAST MEDICATIONS

PLEASE FILL OUT THE FOLLOWING ON ALL **PREVIOUS** MEDICATIONS WHICH WERE USED TO TREAT BEHAVIORAL, PSYCHOLOGICAL, NEUROLOGICAL, OR OTHER SIMILAR PROBLEMS. It is not necessary to fill this out for past antibiotics, etc.

#1) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

When was this medication stopped?

Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No

If yes, how was it changed? Why was it changed?

_____

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

_____

Did the medication help these symptoms?

- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

_____

Why was this medication stopped?

_____

Did this medication have any side effects in you? ☐Yes ☐No

If yes, please explain._____

#2) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

_____

When was this medication started?_____ Which doctor started this medication?_____

When was this medication stopped?

Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No

If yes, how was it changed? Why was it changed?

_____

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

_____

Did the medication help these symptoms?

- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

_____

Why was this medication stopped?

_____

Did this medication have any side effects in you? ☐Yes ☐No

If yes, please explain._____

#3) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____

When was this medication stopped?

Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No

If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?

- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in you? ☐Yes ☐No

If yes, please explain.

#4) Medication Name_____

Dose and Frequency of Medication (e.g. one 250mg tablet two times per day OR 250mg 3 times per day)

When was this medication started?_____ Which doctor started this medication?_____

When was this medication stopped?

Was the medication dosage been changed during the time the medication was taken? ☐Yes ☐No

If yes, how was it changed? Why was it changed?

Why was this medication started? Which symptom(s) or problem(s) was the medication intended to treat?

Did the medication help these symptoms?

- ☐ Yes – the symptoms significantly improved
- ☐ Yes – the symptoms slightly improved
- ☐ No – the symptoms were the same
- ☐ No – the symptoms were worse than before starting the medication

Please explain your answer above:

Why was this medication stopped?

Did this medication have any side effects in you? ☐Yes ☐No

If yes, please explain.